MALE INVOLVEMENT IN THE PRACTICE OF FEMALE GENITAL MUTILATION IN SHONE TOWN

SOUTHERN NATION NATIONALITY REGIONAL GOVERNMENT, ETHIOPIA

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Abstract

Female Genital Mutilation (FGM) has been one of the challenging health related practices which is prevalent in different continents. Though, there are some documents indicating the declining of this ancient surgery often also called circumcision, implementing the eradication program and effect a change as desired has never been easy. Eliminating FGM requires global, national and community involvement.

A cross-sectional study was conducted to evaluate the awareness, involvement and attitude towards FGM among male inhabitants of Shone town, Southern part of Ethiopia.

A total of 333 men were included in the study. Of these 60% were aged between 15 and 30 years. 76% of the study population are from Hadiya ethnic group. More than 50% of the respondents have primary or below primary level of education. Majority of the population are (68%) Protestant in their religion. Married population accounts 58% of the studied subjects. Tradition was the leading reason (94%) followed by increased chances of marriage for practicing FGM.

Significant proportion (80%) of the respondents revealed that they have information about FGM from significant others. Only14% of the studied population got information about FGM from health institution. Most of the men (95%) have heard about FGM from before and of these 32% claimed that the practice has no health impact. Difficulties in labor are the most common complication mentioned by the respondents. Only 43% of the respondents have explained that FGM is cutting (removing) part of female organ and/or removal of clitoris.

The study showed that the level of awareness of the community about FGM is low. The association between awareness, educational level and age is significant ($P < .001$). Married individuals are two times more likely to have low or no awareness about FGM. Very few number of respondents have attended seminar, health education or meeting on FGM. Majority of the discussions about FGM is carried out among colleagues.

A Significant number of the studied subjects have responded that they were involved in the decision to have their daughter or sister mutilated. Only 24% of the total respondents are adequately involved in the prevention of FGM.

A considerable number of the respondents (57%) approved the sustainability of the practice. 64% of the total respondents have positive attitude towards the practice. Educational level, marriage status and source of information are highly associated with type of attitude of the respondents.

In general, the results showed that men are still in favor of the continuation of the practice of FGM. Those who were against FGM tended to be better educated and/or younger, suggesting that younger generations are initiating a change of attitude in the community.

Those respondents who rejected the practice generally agreed that, because of its multi factorial nature, a multi disciplinary approach should be used to initiate change; all possible methods should be integrated for the maximum effect.

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Definition of Terms.

Kebele - A kebele is equivalent to small village
Zone - Sub regional part of the region.
Woreda - Sub zonal part of the zone.

List of Abbreviations

AFRO - African Health Research and Development

AIDS - Acquired Immuno Deficiency Syndrome

BCC - Behavior Change Communication

BCI - Behavior Change Intervention

FDRE - Federal Democratic Republic of Ethiopia

FGM - Female Genital Mutilation

HIV - Human Immunodeficiency Virus

HTPs - Harmful Traditional Practices

ICPD - International Conference on Population and Development

IMR - Infant Mortality Rate

MMR - Maternal Mortality Rate

NCTPE – National Committee for Traditional Practice in Ethiopia

NGO - None Governmental Organization

PHC - Primary Health Care

SNNPRG - Southern Nation Nationality People Regional Government

STD - Sexually Transmitted Diseases

UNFPA - United Nations Population Fund

UNICEF - United Nations Children's Fund

USAID - United States Agency for International Development

WHO - World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 General Background

Ethiopia has an area of 1,112,000 square kilometers with an elevated plateau varying in height between 2,000 and 3,000 meters. Ethiopia borders with Eritrea in the North, Djibouti and Somalia in the East, Sudan in the West and Kenya in the south. Administratively, the country is subdivided in to 11 regional states, 62 Zones, 8 Special woredas and 523 Woredas(1).

The total population of Ethiopia is estimated at about 61.7 million, ½ of them are women, makes it the second most populated nation in Africa with a great number of ethnic groups whose cultures are as rich and varied at their composition (2). Consequently, Ethiopia has plenty of good traditional practices to offer to the world. Her traditions have deep historical roots. Respect for tradition has been considered one of the dominant traits (characteristics) of Ethiopians (3).

However, it is also a country where Harmful Traditional Practices (HTPs) devastating the health and psychosocial conditions of mothers and children abound and are tolerated in the name of traditional identity. The problem of harmful traditional practices is not only a health issue. Its ramification is as wide as life itself. It is a development issue. It is a human rights issue. It is inextricably linked up with the issue of women and gender, child survival and development, the right of girl child, access to health, education and social services, to name just a few.

Ethiopia has one of the lowest health states in the world and this is mainly due to the background socio-economic development resulting in a low standard of living, poor environmental condition and inadequate health services. These health problems are further aggravated by rapid population growth (fertility 6.1 children per women),

environmental degradation and some social cultural factors (1). The leading causes of morbidity and mortality are malaria, TB, acute respiratory infections and diarrhea. Since the first report in 1984, HIV/AIDS has grown into one of the most serious public problems in the country. Some 22,000 AIDs cases were reported by hospitals up to 1996, of those, the mode of transmission for close to 10% was unknown and HTPs have been suspected in some of the transmissions. The number of people infected by HIV is estimated to be about 1.2 million and is growing with clear implications for the study and intervention with regard to HTPs(6,9).

Women and children, the vast majority (75%) of the population, carry the brunt of HTPs in the country. Twenty one percent of the population is women of childbearing age. Marriage is universal and starts early, the mean age at marriage for girls being 17.1 years old, which is one of the lowest in Africa (4). 41.7% of those aged 15 – 19 are currently married, compared, for example, with 0.5% for Sweden. Contraceptive coverage is very low and child bearing is high, with a total fertility rate of close to 7, and starts early. The cost of this high fertility is grave as witnessed by a maternal mortality rate estimated between 700 and 1,400 per 100,000 live births and high abortion rate (often unsafe) and a risk of dying from maternal causes several hundred time higher than those experienced in the developed world (5,6).

Ethiopian women suffer from work stereotypes and a gendered distribution of labor. Most are occupied in economically invisible work. Even though "Girls start taking care of household chores at the age of 6 or 7" and women are known to engage in back breaking domestic and external (farm) work, they are not considered bread winners. Women labor force participation rate (13%) is much lower than men (55%). They lag behind significantly in access to education, work opportunities, etc (7).

Ethiopia is one of the poor country in the world with a per capita income of US$120 (in 1995). Sixty percent of the population is believed to live below the poverty line. Life expectancy is only 48.2 years (in 1994). Infant mortality rate is one of the highest (115 per 1,000) in the world (5).

Education is crucial in the struggle against HTPs like uvulectomy, extraction of milk teeth and circumcision. It empowers people, women in particular, as they are the ones to instigate cultural values in their children, and thus enable them to withstand traditional pressures for conformity. Ethiopia has one of the least educated populations in the world. Mean year schooling is only 1.1 years and 75% of primary school age children, a higher proportion of which are girls in rural areas, are out of school. The literacy rate in 1994 was only 24.1% for female and 44.5% for male (8).

Background of the Study Area

The southern Nation, Nationalities and Peoples Regional Government (SNNPRG) is one of the 11 Regional states of the Federal Democratic Republic of Ethiopia (FDRE). It has an area of 116, 442.5 square kilometers with a population more than 12 millions. The region has boundaries with Oromiya in the southeast, east and north, with Sudan and Gambella in the west and Kenya in the south. Administratively it is divided into 9 zones, 5 special Woreds and 72 regular Woreda.

Climatically, it has got three district zones, namely the Dega (cold zone), Woina dega (temperate zone) and the kola (hot zone) which constitute 22%, 45% and 33% respectively. The annual rain fall of the region ranges from 200 – 2200 mm.

SNNPR is the home of many nations, nationalities and peoples with different dialects and languages. Most of the peoples (over 85%) live in rural areas with low access to health, education and other social services. Agriculture is the main occupation and it is largely of subsistence farming.

The study was conducted in one of the woredas in a small town called shone. The woreda has an area of 542.8 square kilometers (10). While its population including small towns like Shone, Adilo, Wada, Mazoria and Sike denema, is estimated to be about 173,848.

Out of which 89,637 (51%) are male while the remaining 84,211 (41%) are female (11). The dominant ethnic group inhabiting in the woreda as well as in the study area is Hadiya.

Total number of households, in the woreda, is estimated to be 36,446. Of which 17% are female headed. Average size of household is estimated to be 7 persons.
Adult literacy rate for males with 15 yrs and above is about 30% while it is 9% for females, and 27% for both sexes (12).

Polygamy is wide spread, however, it is largely dependent on wealth. Most men cannot afford to marry many wives. Polygamy is becoming less important owing to the spread of Christianity and the impoverishment of the communities. Women play a central role in most aspects of the Hadiya, the dominant ethnic group, economy. However, women are clearly subordinate in Hadiya society and their work is undervalued, as it is the case with most of the nationalities in the country (12).

The daily tasks of collecting fuel wood and water, milling grain, and the burden of bringing up children fall almost exclusively on women. In addition, many women give birth up to 7-8 children in their life. As a social category, women are clearly disadvantaged and are in need of positive discrimination in the planning and implementation of the program. The most disadvantaged women are usually those who head household. The only means of survival for this category of women during the lean season are sales of fire word and petty trade.

The study area is located to the west part of the regional town, Awassa, at a distance of 112 km. Total population is estimated to be 8230 out of which 4129 (49%) are male and 4197 (51%) are female. Total number of household is estimated to be 1703.
It has one all weather-asphalted road connecting the south to the west part of the region and it crosses the town. The whole town, shone, is governed by 01 kebele (local administration).

1.2. Health Service and HTP in Ethiopia

Health services can play an important role in the fight against HTP. Most of the harm though traditional practices are on health. Health institutions are expected to play a very important role in IEC against HTP and in mitigating some of the harmful effects of the practices.

Health service in the country are limited, covering only about 40% of the population and are understaffed and under funded and therefore of poor quality (5,13).
The Health policy emphasizes the equitable access at all people to decentralized preventive and promotive health oriented integrated PHC (14). The plan is to reach the whole population with a system of primary health care units (one health center and five health posts for each 25,000 people) and zonal referral hospitals (one per million population). The target is to cover the whole population with such a system by 2015 and obtain significant improvement in the indicators including close to 50% reduction of MMR and IMR.

The struggle to eliminate Harmful Traditional Practices is formidable. In Ethiopia HTPs specifically FGM have not been studied adequately. The majority of the studies were focused on clinical and psychological complication resulted from the practice. No study has been conducted on male population to evaluate the current knowledge status about FGM and their involvement in the eradication of the practice.

I believe only men who are relatively in better status, in many aspects, can reach their counterparts on this subject, especially since sexuality is involved, to teach them the biological facts in the persuasive way and from their own experience. Unfortunately, no adequate attempt has been made to teach men who make all the decision in each family about the truth regarding FGM. Therefore, this study is aimed to evaluate the awareness level of male population and the extent of involvement in the strategies designed to eradicate this deadly practice and consequently utilize the findings at the community level.

1.3. REASONS FOR THE STUDY

1. Review of the literature shows that the amount of scientific information on FGM is relatively small compared to the problem and complexity of the factor.

2. Many studies in reproductive health, specifically in FGM, considered men as a subgroup of husbands of interviewed women, and therefore not representative.

3. The need for the involvement of male in the eradication of FGM has been stressed repeatedly with out any improvement seen.

1.4. OBJECTIVES

This study is designed to identify the awareness, involvement and attitude of men at the grass root level so that the appropriate strategies would be implemented to hasten the eradication of FGM in the community and by the community. Thus, the study has the following objectives.

General:

Evaluate the influence of male in FGM practice. Use the result of the study in the promotion of better reproductive health and eradication of FGM.

Specific:

1. Determine the level of awareness of male inhabitants on FGM and its complications.

2. Identify the level of male involvement in the prevention or promotion of FGM.

3. Assess the attitude of male towards the practice of FGM.

4. Identify the main reason for practicing FGM.

5. Compare the level of awareness with the attitude of different groups of male inhabitants.

6. Provide possible recommendation for the eradication of FGM in the study area.

1.5. HYPOTHESIS

1. The involvement of male in the prevention of FGM is low.

2. There is association between low level of awareness and involvement of male inhabitants in the practice of FGM.

CHAPTER TWO

REVIEW OF LITERATURE

2.1. General Description of Women's Status

The empowerment and autonomy of women and improvement of their political, social, economical and health status is highly important issue at the global, regional and community level. It is essential for the achievement of sustainable development (15). The full participation and partnership of both women and men is required in productive and reproductive life, including shared responsibilities for the care and nurturing of children and maintenance of the household. However, in most part of the world, women are engaged with performance of many household tasks. With the family, women bear the principal responsibility for maintaining the home and caring for society's dependents-children and the elderly. They collect water and fuel, they cook and feed the family, and they perform other tasks essential to household maintenance.

In all parts of the world, women are facing threats to their lives, health and well being as a result of being overburdened with work and of their lack of power and influence. In most regions of the world, women receive less formal education than men do, and at the same time, women's own knowledge, abilities and coping mechanisms often go unrecognized. For instance, as the principal providers of family health care, women tend to the sick and disabled and protect children. Although not officially recognized as health workers, women are responsible for 70 to 80 percent of all the health care provided in developing countries (16).

Education is one of the most important means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in enhancing socio-economic change.

In 1990, Government meeting at the world conference on education for All in Jomtien, Thailand, committed themselves to the goal of universal access to basic education. But despite notable efforts by countries around the globe that have appreciably expanded access to basic education, there are approximately 960 million illiterate adults in the world, of whom two thirds are women (15).

Widespread poverty remains the major challenge to development effort and improvement of women health status. Poverty is often accompanied by unemployment, malnutrition, illiteracy, low status of women, exposure to environmental risks and limited access to social and health services, including reproductive health services (15). Moreover, women's health status is affected by complex biological, social, and cultural factors that are highly interrelated.

Besides all these political, social and economically related problems, women in developing countries are highly affected by pregnancy related problems, abortion, malnutrition and other culture associated practices like early marriage, abduction and FGM.

Complication to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 percent of them in developing countries (15).

Worldwide, an estimated 40 million to 60 million women resort to abortion to end unwanted pregnancies. Because the majority of abortions are unsafe, the procedure carries a high risk of injury and death, accounting for 125,000 to 200,000 female death annually (17).

FGM is one of the common cultural practices affecting the physical, social and psychological status of the women. It is an old tradition existed as the fifth century B.C. according to Herodotus and was practiced among the phoenicians, Hittiess, and

Ethiopians (18). It is still highly prevalent in most part of Africa, including Ethiopia.

Every year two million girls, globally, are estimated to be subject to genital cutting and this translates to around "6000 girls per day or five every minute"(19). Unlike male circumcision, which is also highly practiced in Ethiopia, in which the foreskin is removed with out serious damage to male organs, FGM has multiple effect on the health status of the women.

Eradication of this ancient practice requires adequate investigation, commitment of social and political leaders and above all the involvement of male in the prevention of FGM. Moreover, elimination of the practice of FGM will not only improve women's and children's health; it will also promote gender equity and women empowerment in the communities where the practice persists.

The government of Ethiopia, in collaboration with different Non Governmental Organizations (NGO) declared its unequivocal commitment to development of women with the announcement of the National policy on women in 1993. Currently, professional women association and the National Committee on Traditional Practices in Ethiopia (NCTPE) are working together in matters that are directly of their concerns. However, despite all the positive and encouraging activities, there are many challenges when it comes to implementation.

In a society where men rule and decide for women who to interact with and who to socialize with, men must be included in all reproductive health programs adequately. In general, while the incidence of FGM may be declining, in some parts, attention need to be focussed on proper community enlightenment as well as the role of male in the decision to mutilate daughters. Thus, this study is focussed on the level of male involvement in the practice of FGM in a town called "Shone" located to Southern part of Ethiopia.

2.2. General Description of Female Genital Mutilation

In the last decades, a wide range of organization and individuals has attempted systematic community based activities for the prevention and elimination of FGM. These efforts are being matched by an increasing effort to bring the problem to the attention of international and national political, religious and community leaders to create an atmosphere of political support for the elimination of the practice.

Despite the considerable number of publications available on this topic most of the literature is on the medical aspects and physical complications of the operation (20). In recent years, however, a psychological dimension was added to the problem (21).

The mortality of girls and women undergoing these practices is probably high but few records are kept and deaths due to FGM are rarely reported. Other factors, which have direct influence on the prevention of FGM like male involvement, are not extensively studied or results may not be disseminated.

FGM is a deliberate procedure, which causes damage to children and women's genitals and which in many cases result in serious health consequences. According to WHO it is defined as all procedures that involve partial or total removal of the female external genitalia and /or injury to the female genital organs for cultural or any other non-therapeutic reasons

Classification of this operation is made by WHO considering the extent and degree of damage to the genital organ.

WHO classification of female genital mutilation:-

Type I - excision of the prepuce with or without excision of part or all of the clitoris.

Type II- excision of the prepuce and clitoris together with partial or total excision of the labia minora.

Type III- excision of part or all of the external genitalia and

stitching/ narrowing of the vaginal opening (infibulation).

Type IV- unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissue(19).

Type I and II are the commonest type of FGM. They constitute up to 80% of all FGM practiced (19). Up until now it has not been possible to determine when or where the tradition of FGM originated. The reasons given to justify FGM are numerous and reflect the ideological and historical situation of the societies in which it has developed.

As to the health consequences of FGM, some documentation and studies are available on the short term and long term physical complications of the different types of FGM.

Women subjected to the more severe form of FGM are particularly likely to suffer from health complications requiring medical attention throughout their lives. Some complication such as severe bleeding and infections may occur immediately or shortly after the practice is performed; other complications may occur years after the event. It is difficult to assess the frequency with which the various complications of FGM occur, as too few surveys have been undertaken to establish the incidence of health consequences.

A review of literature shows that the amount of scientific information on FGM is relatively small compared to the scale of the problem and the complexity of the factors that contribute to its continuation. However, it is apparent that the physical, psychosexual and psychological complications of FGM are sizable and constitute a serious public health problem, which in endangers the life and health of women and children. Hemorrhage, shock, infection, urine retention and injury to the adjacent tissue are some of the immediate complications. As to the long term complications, which is more difficult for none medical and uneducated people to associate with FGM, are sexual dysfunction, difficulty in menstruation, chronic pelvic infections and problems related to pregnancy and child birth are common who have undergone the practice (19).

Reasons cited generally relate to “tradition”, power inequalities and ensuring compliance of women to the dictates of their communities. In sociological studies, the following reasons have been given for the practice of FGM: custom and tradition; religious demand; purification; family honor; hygiene (cleanliness); aesthetic reasons; protection of virginity and prevention of promiscuity; increasing sexual pleasure for the husband; giving a sense of belonging to a group; enhancing fertility; and increasing matrimonial opportunities (19).

FGM is more than cutting a part of the body. A study done in Sudan in 300 polygamous Sudanese men identified that each of them had one wife who had been infibulated and one or more who had not. 266 expressed a definite sexual preference for the uninfibulated wife; in addition, 60 said they had married a second, uninfibulated wife because of the penetration difficulties they experienced with their first wife (22). Under such conditions, marital dissolution may occur, especially if a woman’s fertility is affected.

The age at which the mutilation is carried out varies. The practice may be carried out during infancy, childhood, at the time of marriage or during a first pregnancy. The most common age seems to be between four and ten, although it appears to be falling, indicating a weakening of the link to initiation into adulthood (22).

The procedure is carried out with special knives, scissors, scalpel, and pieces of glass or razor blades. There is often additional unintended damage due to crude tools, poor light and specific conditions. The procedures are usually carried out by elderly women of the village who has been specially designed for this task, or by traditional birth attendants. In urban areas, more affluent families may prefer to use the services of health personal such as midwives and doctors although the medicalization of the procedure has been consistently condemned by WHO (19). In Egypt, for example, preliminary results from the 1995 Demographic and Health Survey indicate that the proportion of women who reported having been circumcised by doctor was 13%(23).

2.3. Male Involvement in the Practice of Female Genital Mutilation

The word " involvement" by itself connotes participation or engagement. Involvement may be defined in relation to FGM as "the extent (level) of participation or engagement of men in deciding, supporting or performing the practice of FGM".

As in other reproductive health programs, the involvement of male in the prevention of FGM seems limited. General awareness of FGM problems has increased considerably and plans for eradication exist in many different places. Considerable financial resources are forthcoming for FGM research, including research in communities where the practice has disappeared. However, male involvement remains elusive and there is a dire need for practical recommendations on how to involve men in the eradication of FGM (24).

In many cultures including Ethiopia, men make decisions about such health-related concerns as financial management, family size, birth spacing, and use of health care.

In Senegal, a study seeking to learn why so few women used maternal health services found that only 2% of the women interviewed said they would decide for themselves to seek care in the event of pregnancy related complications. For most the decision rested with their husbands.

A study carried out in Nigeria identified that the decision to circumcise the babies was taken in over 90% of cases by husbands even though this was opposed by wives in 19% of cases (25).

Another study carried out in Sudan where the most severe type of FGM is being practiced, identified that a girl who had not undergone genital mutilation is simply not marriageable, and the tighter infibulation, the higher the bride price that can be obtained. Similarly, a study done in eastern part of Ethiopia found out that FGM is becoming less important for marital reasons, but men still seems to prefer marriage to mutilated women (26).

In all the above studies, it is clearly shown that male has contribution to the sustainability of the practice. But what if men said that they would marry unmutilated women? A study carried out in Sudan identified that many men alleged they had experienced complications due to FGM and said they would have preferred to marry a women not subjected to it (27). If such male experiences and attitudes come to the surface, the vicious circle of false expectations and silence concerning FGM would stop and a possibility of eradication of this ancient practice would open.

People may argue that men are already too involved in reproductive health as policy makers, service providers, or husband. But, unfortunately in a place where the practice is widely experienced and where most people are not educated, the involvement in the prevention and eradication of FGM could be low.

There can be different reasons for having such experiences from the male side. Some of them might be; lack of awareness, fear of breaking cultural laws and attempts to keep gender power imbalance in the community. Moreover, since male are not experiencing the practice the female do, problems related to FGM may not be considered crucially and consequently the involvement in the eradication aspect could become insignificant.

Men play a very critical role in the continuation of the practice. They have been excluded as a target group for decades from all educational programs on at the grass root level in Ethiopia. A study done in Eritrea explains that those who favored the continuation of the practice of FGM were more likely to be rural dwellers with little formal education (28). Similar studies in Nigeria detected that maternal low educational status is significantly related ($P<0.01$) to the tendency to circumcise the babies (25). Thus the impact of poorly educated parents is passed on to the daughters. This can be one of the major reasons why the practice still prevails to day.

Indeed girls have very little choice. Given their age and their lack of education and resources, they are dependent on their parents, and later on their husbands, for the basic necessities of life. Because of their lack of choice and the powerful influence of tradition, many girls accept circumcision as a necessary and even natural, part of life, and adopt the rationales given for its existence.

In a society where men rule and decide for women who to interact with and socialize with, men must be included in all reproductive health programs adequately. In general, while the incidence of FGM may be declining, attention needs to be focused on proper community enlightenment as well as the role of the male in the decision to circumcise daughters.

2.4. Male Awareness about Female Genital Mutilation

The first step in influencing health related behavior is often to increase awareness of conditions that put women at risks. For example, most women and their families are not aware of the warning signs of pregnancy related complications and so do not respond properly to them. Public education programs can promote actions in the home or community to improve women's health and prevent future health problems. Public education programs can also discourage unsafe practices that harm women's health (such as FGM, risky sexual behavior, inadequate food consumption during pregnancy, unsafe delivery practices and others). Information needs to target not only women but also their parents, husbands, in-laws, and village leaders. Husbands, in particular, have a major impact on women's work load, diet, exposure to Sexually Transmitted Diseases (STDs) and some harmful traditional practices like FGM.

Many people in the societies concerned, including men, do not naturally see the link between genital mutilation suffered by a woman in her childhood and the pain, infections and health problems she may suffer in her later years. Moreover, large number of people may think that FGM is similar procedure to that of male circumcision.

Many men point out that males undergo circumcision and similar rites of passage too and, as such, FGM is not a mechanism used by men to oppress women. There are similarities and dissimilarities between FGM and male circumcision and also between the rites of passage for boys and girls. Certainly the two procedures are related. Both are widely practiced with out medical necessity and in both cases children go through a traumatic experience. Both are performed on children without their consent. But, there the parallel ends. The clitoris is biologically equivalent to the penis. Clitoridectomy, which is the most common form of FGM, is analogues to penisectomy rather than to circumcision. Male circumcision involves cutting the tip of the protective hood of the skin that covers the penis but does not damage the penis, the organ for sexual pleasure. Clitoridectomy damages or destroys the organ for sexual pleasure in the female (29).

So far, very few studies had been conducted to assess as to how the level of awareness of male in the practice of FGM in Ethiopia. Therefore, it is difficult to describe the current level of awareness among male population.

However, a study conducted in Egypt using loosely structured in depth interviews with sixty men have found that men do not possess accurate information about male and female biological reproductive systems and have no access to sex education. Not only this but also men possess limited knowledge about FGM. Moreover, the study identified that men are the principal decision-makers in the question of whether or not to circumcise their children (30). It is believed that educated and influential people should set an example by abandoning circumcision in their own families. Thus as part of effort to eradicate FGM in Ethiopia, ground breaking research is needed to explore the awareness level of male inhabitants.

2.5. Attitude towards Female Genital Mutilation

Behavior change is the goal of all health communication programs, including those aimed at the elimination of FGM and other harmful traditional practices. Overtime, the field of health communication has evolved from the traditional Information, Education, and Communication (IEC) strategies to Behavior Change Communication (BCC) to Behavior Change Intervention (BCI). The evolution in terminology is a reflection of the increased recognition of the complexities and difficulties associated with behavior change (31).

In behavior change communication, the field of health communication goes beyond developing the right messages for any particular audience to the recognition that behavior change may also require skill building, for example how to resist being pressured to have a daughter excised, and building community support to sustain the change. Behavior change interventions additionally recognize that the desired behavior change must be feasible and structurally encouraged (31).

Several behavioral scientists, including Everett Rogers and William McGuire, described the steps an individual must pass through in order to adopt the desired behavior. These steps include: 1) awareness; 2) seeking information; 3) personalizing the information; 4) examining options; 5) reaching a decision; 6) typing the behavior; 7) receiving positive reinforcement; and 8) Sharing the experience with a large group (32). For example, the decision to reject FGM as a mother, grand parent, father, husband, aunt, teacher, older sibling, or a girl involves changes at different levels, including knowing that refusal is an option; finding such a choice desirable; reaching the decision to reject the tradition; figuring out how to put this decision into action; doing it and seeing what happens; and receiving positive feedback that allows the decision to stand (31).

An attitude is a relatively enduring organization of beliefs around an object or situation predisposing one to respond in some preferential manner. And a belief is any simple proposition, conscious or unconscious, inferred from what a person says or does, capable of being preceded by the phrase “I believe that…”(33).

For this particular study, attitude may be defined as away of thinking, feeling or behaving towards the practice of FGM.

In this study attitude is considered as one of the determinant factor, which can influence the involvement of male in the prevention or eradication of FGM.

There are conflicting accounts of the African male attitude towards FGM. Many would not take a public stand on FGM although in private they may profess to be against the practice. Fathers have equally ambiguous positions. Most men in rural and poor communities practicing FGM have not been given the opportunity to give their opinion on this traditional practice (29).

In Sudan, a 1981 study found that men are some what more likely than women to believe FGM should continue, but less than half as likely as women to prefer infibulation (22). Similar studies on attitude of Sudanese people to the practice of female circumcision identified that the community is still in favor of the continuation of the practice (34). Another study done in eastern part of Ethiopia revealed that men still seem to prefer marriage to circumcised women (26).

A study carried out in two neighboring countries, Sudan and Eritrea, showed that in Eritrea men are slightly more likely than women to favor discontinuation and that men who believes the practice should be stopped are about twice as likely as their female counterparts to cite medical complication as reasons.

FGM is not just a health problem but a broad social problem, intertwined with gender power relations, sexuality, self-identity, social institution. It therefore important not only to treat the physical and psychological injuries that results from violence, but also to examine the root causes and address the cultural and social legitimization of bodily harm and male control over female behavior and attitude (35).

In all the above studies, men are playing a significant role in propagating the practice in the community having a positive attitude towards FGM. Thus, the aim of this study is to identify male's attitude of Shone town inhabitants and detect the most influencing factor.

2.6. Harmful Traditional Practice in Ethiopia

Like most societies in a pre-industrial stage of development, the ethnic cultures in Ethiopia are interwoven with myths, superstitions and conception of man, with his psychic and sexual life, which sometimes contradict the basic findings of science. As a result, these are traditional practices in almost all ethnic groups of the country which adversely affect the health of the people, goals of equality, political and social right and the process of economic development.

According to a joint WHO/UNICEF/UNFPA statement (A Joint WHO/UNICEF/UNFPA statement: Female Genital Mutilation, WHO, 1997, Geneva) the "norms of care and behavior based on age, life stage, gender and social class are often referred to traditional practices". Critics assert that it is difficult to judge whether a particular traditional practice is harmful or beneficial. But human beings in the present country are quite knowledgeable about the physical and psychological nature of man. We now have a more thorough understanding of the structure and function of the human body as well as human psychic and social life. It should be possible therefore to objectively assess and judge whether a traditional practice is harmful to man, and therefore incompatible with accepted scientific theory and practices.

HTPs like milk teeth extraction (89%) uvulectomy and Female Genital Mutilation (73%) appear to be widely distributed in the country. Eight HTPs (FGM, massaging the abdomen of pregnant women, drastic measures to hasten the placenta, Early marriage, shaking after delivery, marriage by abduction, food discrimination and bleeding after expulsion of placenta) are performed on women. Children on the other hand are subjected to six HTPs (uvulectomy, tonsillectomy, keeping children out of the sun, preventing food and fluids from children with diarrhea and feeding infants with fresh butter).

More and more it is recognized that women, from infancy to adulthood, and children, suffer to the most effects of traditional practices as in the allocation of family food resources, nutritional taboos, circumcision, early marriage or marriage by abduction.
The universal Declaration of human rights (Article 5) states that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment". The practice, however, in many parts of Ethiopia contradicts their right. People are engaged in various harmful traditional practices including FGM, uvulectomy and milk-teeth extraction.

The marriage law in Ethiopia stipulates that marriage is by mutual consent and not less than 15 years (36). However, marriage by abduction and early marriage (below 15 years of age for girls) are rampant in many parts of this country.

The health of Ethiopian children too is threatened by some traditional practices. It may be recalled that convention on the rights of the child (Article 24.3) states that "parties shall take all effective and appropriate measure with a view to abolishing traditional practices prejudicial to the health of children". However, milk teeth extraction, keeping a baby out of the sun, force feeding fresh butter to new born children, and other harmful traditional practices are still affecting the health and well being of children in Ethiopia.

2.7. Female Genital Mutilation in Ethiopia

Female circumcision is still a common practice in many parts of Africa though it appears that its popularity is waning. Ethiopia is one of the East African countries where female circumcision is widely practiced (37,38,39).

A potential hypertrophy of the clitoris –by which is meant an unusual enlargement of the organ –is cited as reason for excision in Ethiopia and also in parts of Nigeria. The Catholic Church has sanctioned the genital mutilation of all female children of its converts on those grounds since the 17th century when the pope sent a medical mission to Ethiopia (42).

Mustafa stated that since early Christian times Jesuit missionaries have referred to excision of the hypertrophied clitorises and labia minora in Abyssinia and the church had to withdraw its prohibition of circumcision in female converts because the men were repelled and would not marry uncircumcised women (38,39).

James Bruce, the Scottish explorer, explained that he was told the reason for the operation is hypertrophy or an abnormal enlargement of the clitorises, which was supposed to be indigenous with Ethiopian women. Bruce's report was quoted by Dr. Ploss in every edition of his famous work "WOMAN", first published in 1885. The astonishing fact is that Bruce's tale of hypertrophy of the clitoris as reason for excision has been quoted ever since through out the medical literature as a fact explaining why excision is necessary in Ethiopia. Yet no one shared of medical evidence has ever cited to confirm this alleged enlargement of the genitalia in Ethiopian women, and also to this day there is no a single factual report on observation to confirm this hypertrophy any where in the medical literature nor from physicians in Ethiopia (37,39).

According to the baseline survey conducted in Ethiopia in 1997, FGM is practiced in a varying degree in all regions except Gambella and among a number of ethnic groups in SNNPR. It is practiced in both the rural and urban communities and by various religious

groups (40).

Over 90% of the Ethiopian women are believed to undergo at least one of the four forms of FGM. Infibulation is practiced, to a varying degree, in 5 ethnic groups (Somali 90%, Afar 63%, Berta 10%, Harari 5% and Oromo 1%). Sunna is the most frequent FGM (over 50% of the circumcision among the Agew, Kamyr, Argoba, Fadashi, Goffa, Harari, Kebena, Oromo, Siltie and Werji ethnic groups followed by clitoridectomy and excision)(40).

The most common reasons for practicing FGM are the following:

- Hygiene
- Guarantee for virginity
- To cool off sexiness
- Beauty (the removal of the clitoris)
- Better sexual performance
- Religion
- Tradition
- Fear of stigma
- Improved pleasure (for men), and
- Increase matrimonial opportunity

Female Genital Mutilation is most frequently carried out at home or sometimes at the circumciser's house. Often the operations are performed by experienced older women, circumcisers are remunerated in kind or cash even though they may have other job; some traditional birth attendants perform other traditional practices.

The age at which Female Genital Mutilation is performed and the type varies from area to area depending on the culture of the different ethnic groups in the country. In some cultures FGM is performed before the eighth day or between the age of 1 – 10 years. For some it is performed at betrothal, a few day before marriage or the day after marriage (40)

CHAPTER THREE

METHODOLOGY

3.1. Study Type

The design of the study was cross sectional and carried out from Septe-Nov 2001. The main reason for choosing this method was that it enables to measure events at a given time and also allows the researcher to test the hypothesis with a limited time frame. Further more, the design has a medium selection bias compared to others and no follow up is required (41).

Due to the nature of sensitivity and complexity of the topic and the issue of validity, both qualitative and quantitative (triangulation) methods were used to explore the required information for the study.

3.2. Study population

Total population of the town was 8230 and of these male accounts 4129. According to 1998 health and health related indicators, 44.7% are under 15 year (1).

In this study, all men who reside in the town and whose age are 15 and above were included in the sampling frame. Therefore, the total study population were 2000 male inhabitants of shone town.

The inclusion criteria were: -

- Sex- male
- Inhabitants of the town
- Fit for interview and age fifteen and above.
- Volunteer to be interviewed

Since there was no base line data indicating the level of male involvement both at the national and regional level, the sample size was calculated by using the following formula and compared with published tables for determining sample size. A 95% confidence interval and P=.5 were assumed in the equation.

$$n = \frac{N}{1+N(e)2}$$

n= sample size

N= population size
e= level of precision

Therefore, the total sample size of the study was 333 men of the Shone town.

3.3. Data collection technique

Two weeks before data collection, a pre-test was carried out in the same population by the principal investigator. Draft of questionnaire were used to interview 15 people of the target group. After interviewing, respondents were given a chance to explain whether any question unclear, produced anger or anxiety.

Based on the results of pre-test, changes have been made on the structure of the questionnaire before data collection began. The questionnaire comprises of socio-demographic and informational variables like awareness, involvement and attitude.

Four male research assistants filled the questionnaire after adequate training as to how to collect data using interview methods. Males completed grade 12, speak the local language and reside out of the study area were some of the selection criteria for research assistants.

To minimize unreliability of the study, clear and unambiguous instruction were given to the respondents prior to interviewing. Maximum efforts were made to keep the privacy and increase confidentiality of the subject. Additionally, focus group discussions were made with different groups of the community.

3.4. Sampling method

The local administration registration books were used to find out those households with eligible respondents. A Lottery method was applied to select the required number of households. Newly constructed houses which are not in the registration but with in the vicinity of the town were also included after having adequate information about there family status. As the study involves no experimentation on human study subjects, the major ethical issue considered was informed consent and confidentiality.

3.5. Data analysis

The data was coded, entered and cleaned before analysis. SPSS version 9.0 was used to analyze the data. The results were presented in tables, graphs and diagrams.

CHAPTER FOUR

RESULTS

The sample consisted of 333 men of whom 60% aged between 15 and 30 years and 40 % are age greater than 31 years. Mean age of the respondent is 31 years. Ethnic distribution revealed that 76% were Hdiya, 8% Wolayita, 7% Amhara, 4% Kembata. The remaining 5% are Gurage, Sidama, Dorze and Oromo. Most of them (68%) were Christians followed by 20% Orthodox and 4.5% Islam. Occupationally, 18% were government employee, 24% farmer, 27% private business, 21.6% students and 1.5% daily laborer. The remaining 8.4% were retired, disabled, beggar or jobless. 12.6% of men were illiterate, 7.8% could read and write, 35% primary education, 37% secondary education and 8% post secondary level education. (Table 1,6,5,2 & 4).

Significant proportions of the studied population (80%) revealed that they have information about FGM from significant others, 14% from health institution, 13% from radio and 9.5% from school. Majority of the respondents (73%) have single source of information, 21% have multiple source. Most Female Genital Mutilation 51% are being carried out by the elderly mothers, 22% pottery makers, 21% by health personnel, 5.1% traditional birth attendants and 1% responded do not know.

Out of the studied population 58% were married, 41% bachelor, 1% divorced and .3% widower. About half of the respondents (50%) have daughters and of these 36% had already mutilated their daughter, 45% will be mutilated at some age in the future and 17% said that they will not be mutilated. A large proportion of the subjects 254(81%) had one or more sisters. Among these 222(71%) had mutilated sisters, 25(10%) will be mutilated and 8(3%) will not undergo the procedure.(table 10)

With regard to awareness, 95%(315) have heard about FGM from before and of these 106(32%) claimed that the practice of FGM has no health impact. 84% of the respondents already knew that FGM could cause difficulties during labour, 46% bleeding, 43% transmission of infectious diseases, 22% infection, 17% were aware that Female Genital Mutilation could lead to sexual discomfort, 16% difficulty in urination and 5% knew that FGM could lead to menstrual problem.(table 7)

Difficulties during labour, bleeding and transmission of infectious diseases are the most known complications of FGM by the respondents where as sexual discomfort, difficulty in urination and menstrual problems are the least known complications.

86% (271) of the subjects knew that the practice of FGM is very common in the area. “Tradition” was the leading reason (94%) among the respondents for practicing FGM followed by increase chances of marriage (47%). (table 9)

Out of the respondents (315), 43%(136) defined genital mutilation as “cutting (removing) part of female organ and/or removal of clitoris, 24%(76) removing extra skin from female organ, 12%(37) cleaning, 11% removal of dirty part from female organ and 9% said don not know.

Only 14.6% of the respondents have attended seminar, health education or meeting on FGM. A significant proportion of men 106(33.7%) had been involved in the decision to have their daughter/sister mutilated. 50.7%(109) of men have expressed their opinion that they would agree on their wife’s suggestion not to mutilate their daughter, the rest 27% decided to mutilate and 22.3% have expressed that they would convince her to have their daughter mutilated. Among the total subjects’ (315), 22.5% had a discussion about FGM. Of these, 48% had with colleagues, 25.4% with family member, 12.7% with health personnel, 5.6% with wife and 3% with religious leaders. Discussion among colleagues is the most common type of discussion held by respondents.

A considerable proportion of the population (57%) approved the sustainability of genital mutilation. Reasons for approving sustainability of FGM were; culture and tradition demand (35%), required to have marriage (25%), essential for cleanliness (10%), difficult to take an action individually (14%), religious demand (3.3%) and for other reasons (4%). (table 11, 12)

Focus Group Discussion

The detail cultural dimension and the meaning aspect of FGM require highly structured interview and also need longer time. However, in this study efforts had been made to explore the cultural value and beliefs about the Female Genital Mutilation through focus group discussion(FGD). Two focus group discussions were conducted: with religious leader and inhabitants of the town.

Six members for each group were selected purposefully and age was considered as one of selecting criteria for inhabitants of the town so that respondents contribute freely to the discussion. The discussion was mediated by the researcher and one reporter who had adequate education, experience in taking a note in the meeting and also speaks the local language. Necessary precaution and preparation were made before FGD. Convenient time was selected, members were invited two days before the meeting and no clue had been given what the meeting all about. A room was organized in such a way that all group members' face each other during discussion and efforts had also been made to create conducive environment for better communication. The discussion was held for one hour and both of them were tape recorded after getting permission from respondents.

Discussion points :-

- marriage and other social practices in the area.
- Common cultural practices
- Cultural practices in relation to FGM
-

the content of focus group discussion were categorized based on each research objective and complemented with other findings in the discussion part. However, the main result of the discussion were summarized as follow:-

-Fear of stigmatization and difficulty in getting married were the main reasons for practicing FGM .

-Opinion differences between two groups were observed.

-The practice has no background of religious demand.

-Parents who decided not to mutilate their daughters were lacking reinforcement or positive feedback.

-Increased demand of parents for financial support both from community and bridegroom.

Table 1

Respondents age in broad group (N=333)

Age group(year)	*frequency*	*Percent*
15 - 30	199	59.8
31 - 45	89	26.7
> 45	45	13.5
Total	333	100

Table 2

Categories of respondents occupation (N=333)

Occupation	*frequency*	*Percent*
Government employee	59	17.7
Farmer	79	23.7
Private business	90	27
Daily laborer	5	1.5
Students	72	21.6
Others	28	8.4
Total	333	100

Table 3

Marital status of the respondents (N=333)

Marriage status	*frequency*	*Percent*
Single	136	40.8
Married	192	57.7
Divorced	4	1.2
Widower	1	.3
Total	333	100

Table 4

Religious status of the respondents

Religion	*frequency*	*Percent*
Islam	15	4.5
Protestant	227	68.2
Catholic	17	5.1
Orthodox	66	19.8
Others	8	2.4
Total	333	100

Table 5

Ethnic background of the respondents

Ethnicity	*frequency*	*Percent*
Hadiya	254	76.3
Wolayita	26	7.8
Amhara	23	6.9
Kembata	14	4.2
Others	16	4.8
Total	333	100

Table 6

Source of information about FGM(N=315)

Information source	*frequency*	*percent*
Significant others	253	80
Health institution	44	14
Radio	40	12.7
School	30	9.5
Community leader	18	5.7
News paper	8	2.5
Other sources	6	1.9

Table 7

Complications of Female Genital Mutilation mentioned by the respondents (N=209)

Complications	*frequency*	*percent*
Labour difficulty	176	84
Bleeding	97	46
Transmission of infectious diseases	89	43
Infection	45	22
Sexual discomfort	35	17
Difficulty in urination	34	16
Menstrual problem	11	5
Others	10	4.8

Table 8

Number of FGM complication mentioned by the respondents.

complication	*frequency*	*Percent*
00	125	37.5
1	59	17.7
2	69	20.7
3	42	12.6
4	24	7.2
5	9	2.7
6	2	.6
7	2	.6
8	1	.3
Total	333	100

Labour difficulties and bleeding are the two most common combinations of complications mentioned by the respondents.

Table 9

Respondents response on the reasons for practicing FGM (N=315)

Reasons	*Yes*	*No*
Custom and tradition	297	18
Religious demand	4	311
Purification	27	288
Family honor	34	281
Hygiene	70	245
Protection of virginity	22	293
Prevention of promiscuity	8	307
Sexual pleasure	7	308
Control sexuality	25	290
Chance of marriage	148	167
Improve fertility	10	305
Other reasons	7	305

Table 10

Status of the respondents family Vs the practice of FGM.

Have daughter(N=189)					**Have sister(N=315)**				
Yes				No	Yes				No
Mutilated	Not mutilated	Will be mutilated		33	Mutilated	Not mutilated	Will be mutilated		61
56	100	Yes	No		222	32	Yes	No	
		74	26				25	8	

Table 11

Responses on the approval of FGM (N=315)

Approval	*frequency*	*Percent*
Yes	181	54.4
No	134	40.2
Total	315	100

Table 12

Reasons mentioned for approving sustainability of FGM

Reasons	*frequency*	*Percent*
Essential for cleanliness	18	9.9
Culture and tradition demand	63	34.8
Required to have marriage	45	24.9
Difficult to take an action individually	17	9.4
Increase chance of marriage	25	13.8
Religious demand	6	3.3
others	7	3.9
Total	181	100

Table 13

Reasons mentioned for not approving sustainability of FGM

Reasons	*frequency*	*Percent*
Expose for different diseases	25	18.7
Predisposes for labour difficulty	31	23.1
Reduces sexual desire of the female	8	6
Post circumcision ceremony is expensive	19	14.2
Dangerous for life	34	25.4
Religious prohibition	12	9
Others	5	3.7
Total	134	100

Table 14

Preferred methods for eradication of FGM

Reasons	*frequency*	*Percent*
Educating the community through existing institution	61	45.5
Legislation	26	19.4
Avoiding stigmatization	23	17.2
Continuos follow up by respected government body	16	11.9
Creating job opportunity for mutilators	5	3.7
Others	3	2.2
Total	134	100

Table 15

Respondents opinion on the reasons for the continuation of FGM

Suggested reasons	*frequency*	*Percent*
Fear of social criticism	33	24.6
Health personnel continue to perform it	13	9.7
Insufficient health education	32	23.9
Increase the chance of marriage	16	11.9
Sustain the culture and tradition of circumcision	37	27.6
others	3	2.2
Total	134	100

Table 16

level of awareness of the respondents on FGM as measured by defining the term and mentioning complications.

Awareness level	*frequency*	*Percent*
High awareness	82	24.6
Average awareness	29	8.7
Low awareness	92	27.6
No awareness	130	39.0
Total	333	100

Table 17

Respondents broad age group Vs Level of awareness on FGM (N=333)

Age group	*Level of awareness*				*Total*
	High	Average	Low	No awareness	
15-30	58	20	53	68	199
31- 45	18	6	22	43	89
>45	6	3	17	19	45
Total	82	29	92	130	333

Table 18

Educational background Vs level of awareness on FGM (N=333)

Status of education	*Level of awareness*				*Total*
	High	Average	low	No awareness	
No education	2	2	10	28	42
Read and write	2		6	18	26
Primary edu.	23	11	28	54	116
Secondary edu.	42	14	41	26	123
Post secondary	13	2	7	4	26
Total	82	29	92	130	333

Table 19

Involvement level of informants in the eradication of FGM (N=333)

Level of involvement	*frequency*	*Percent*
Adequate involvement	81	24.3
Inadequate involvement	202	60.7
No involvement	50	15
Total	333	100

Table 20

Educational background of the respondents Vs level of involvement in the eradication of FGM.

Status of education	*Involvement level*			*Total*
	Adequate	Inadequate	No involvement	
No education		28	14	42
Read & write	4	9	13	26
Primary edu.	14	87	15	116
Secondary edu.	47	68	8	123
Post secondary	16	10		26
Total	81	202	50	333

Table 21

Attitude towards FGM: by total and percent (N=315)

disagreeing or disagreeing strongly with statements	*frequency*	*%*
Believe female circumcision is not a health problem in the community	175	55.6
Believe circumcision should continue	130	41.3
Circumcised women are not faithful in their marriage	147	46.7
Prefer circumcised women for marriage	128	40.6
Circumcision is a way of caring for beloved children	161	51.1
For successful marriage women must be circumcised	154	48.9
Circumcision gives more sexual pleasure	182	57.8

Table 22

Respondents attitude towards the practice of FGM (N=315).

Attitude	*frequency*	*Percent*
Negative attitude	113	35.9
Positive attitude	202	64.1
Total	315	100

Table 23

Characteristic associated with awareness and the likely hood of having high or average awareness level.

Variables	*Odds ratio*	*P-value*
Educational background		
-Primary and secondary	.278[a]	.000
-secondary	.836	.322
-post secondary	1.364	.435
Age (in year)		
-15 – 30	.645[b]	.002
-31 – 45	.369[a]	.000
->45	.250[a]	.000
Marital status		
-single	.744	.088
-married	.381[a]	.000
Involved in decision to have mutilated daughter		
-Yes	.359[a]	.000
-No	.659[b]	.003
Information source		
-single	.485[a]	.000
-multiple	.780	.293

[a]p<.001

[b]p<.01

Table 24

Logistic regression model of characteristic associated with negative attitude towards the practice of FGM.

Variable	*Odds ratio*	*P-value*
Educational background		
-primary & below primary	.440[a]	.000
-secondary	.671[b]	.031
-post secondary	1.000	1.000
Information source		
-single	.415[a]	.000
-multiple	1.355	.200
marital status		
-single	.819	.257
-married	.406[a]	.000
-widower/divorced	1.000	1.000
Age (year)		
-15 – 30	.661[c]	.006
-31 – 45	.441[a]	.000
->45	.419[c]	.009

[a]p<.001

[b]p<.05

[c]p<.01

Figure 1

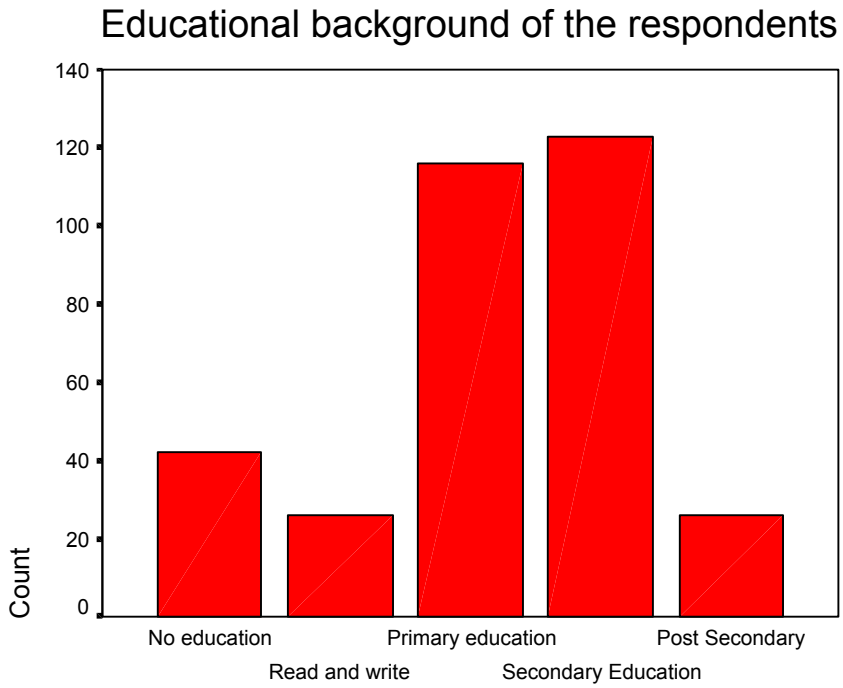


Figure 2

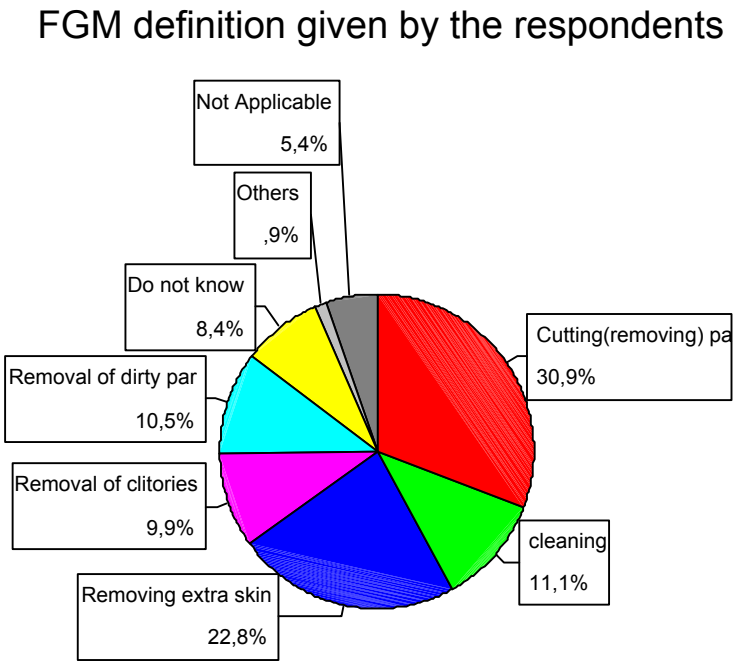
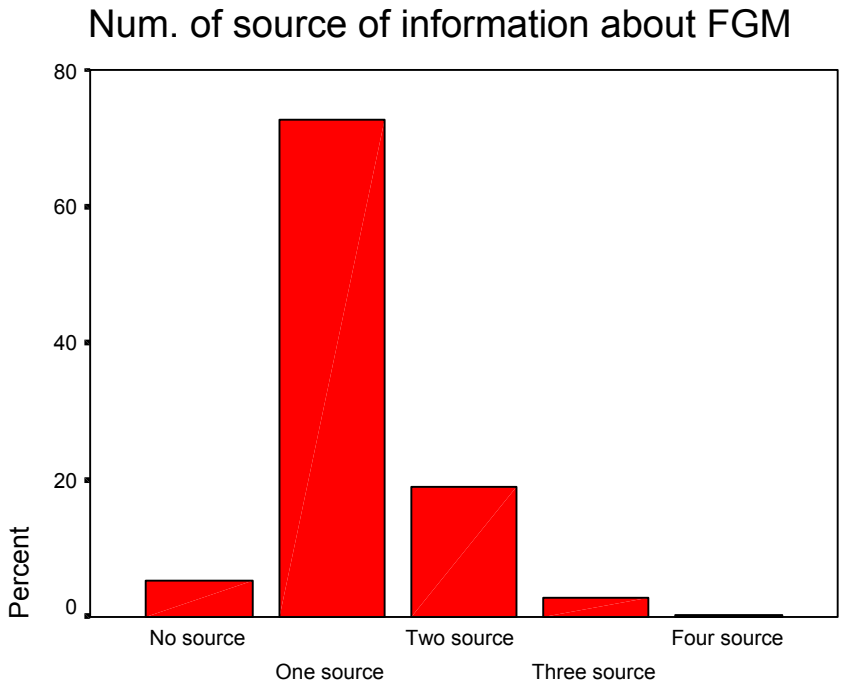


Figure 3



Of those with two sources, radio and information from significant others are the common one.

CHAPTER FIVE

5.1. **DISCUSSION**

Methods: appropriate and validity

Though it is believed that cross sectional method is the appropriate study design for this particular research, due to time constraints and complexity of the topic all factors which may have relationship with different variables were not exhaustively explored. However, the present findings could give us a base line information for further investigation and could also indicate the current move in the study area towards eradication of FGM.

Efforts were made to increase the validity of the study by taking precaution in designing the instrument of data collection. However, there may be some degree of interviewer bias and the measurement has not gone through a formal validity test.

To our opinion, the sample size taken for this study adequately represents the study population. However, the results can not be used to generalize for all ethnic groups, as the diversity is so significant. However, some of the issues raised and concerns mentioned are believed to be common for Ethiopian men.

Discussion

Currently the continuing practice of Female Genital Mutilation through out the world is a cause of great concern. Advocacy by women's group has placed FGM on the agenda of governments as well as regional and international organizations. WHO, the United Nations Children Found (UNICEF), the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID) and others have condemned the practice.

The 1994 International Conference on Population and Development (ICPD) held in Cairo spotlighted the matter in the conferences recommendation.

"Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organization and religious institutions to eliminate the practice" (43).

The World Health Organization regional offices for Africa (WHO/AFRO) is strongly against the idea of FGM and launched on March 1997 a continental plan of action aimed at eliminating FGM (44).

Although a remarkable degree of consensus has been reached among International agencies, policymakers, and women's health advocates that the practice of genital mutilation should be eliminated, such consensus is not necessarily shared by those who perform the operation or the families responsible for having girls excised. Thus, the campaign to abolish FGM will have to mobile all possible means to change the awareness, attitude and practice of those who continue the operation and also of its influential advocates.

The main aim of this study was to evaluate the knowledge, involvement and attitude towards FGM amongst male, which are the detrimental factors for subsequent eradication of the practice.

According to the response of the subjects (86%), FGM is very common in the study area. “Land-belechema” is the local terminology given to the practice of FGM. Most frequently, it is carried out at home or some times at the circumciser’s house. A feast is often organized to mark the occasion whereby close relatives and neighbors are invited to celebrate. Depending on the wealth and status of the parents, the number of guests could vary. Often the operations are performed by “experienced” people. Elderly mothers (50.8%), pottery makers (22%), health personnel (21%) are the three most common circumcisors in the study area. Some respondents explained that the preference for health personnel circumcisors is increased because of fear of HIV/AIDS transmission which can be resulted from unsterile technique. This may also be associated with socio-economic status and educational level of the parents.

However, the choice of elderly mothers and pottery makers for their long-term experience is still unchanged. In the contrary to the position given for pottery makers in the community, they are welcomed to each family for their “skillful” surgery. Circumcisors are remunerated in kind or cash and as to the cost, 49.2%(124) said cheap 46%(116) expensive and 4.8% (12) reasonable. Most respondents have emphasized more on the high expense of the feast held during circumcision ceremony.

In the dominant part of the ethnic group, unlike other areas, the age at which FGM is performed from 9 to 13 years. The group member explained that this is one of the steps to be taken by the parents in the preparation of their daughter for successful marriage.

Identifying the local sources of information and determining the more trustworthy, considered by the community, is crucial for effective strategy to eradicate FGM. In this regard, the study has detected that information from significant others (80.3%) are the leading source in the community. Discussion about the issue of reproductive health has been considered as a taboo especially among family members. Most discussions are being carried out among colleagues. Thus, in my opinion, finding the network among the community where the issue of FGM is discussed has a paramount importance for successful implementation of the battle against the practice of FGM.

A study conducted in Egypt among sixty men have found out that men do not possess accurate information about male and female biological reproductive systems and have no access to sex education (30). In this study, the meaning of FGM given by the respondents varies greatly. Only 43.2%(136) of the respondents have associated the meaning to the part of the organ affected by mutilation stating as “cutting (removing) part of female organ and/or removal of clitoris”. Some (24.1%) have defined FGM as “removing extra skin from female organ”. The respondents who gave the late definition seem to have no idea about the external female genital organ as they have tried to similarize with male circumcision. They had understanding that the part to be mutilated is a foreskin as that of male organ. Others (22.8%), have conceived that female genital mutilation means cleaning or removal of dirty part from female genital organ. Some of the group members in focus group discussion thought that it is difficult to keep the genital part clean unless it is circumcised.

Significant number of the respondents (36.2%) has no idea about the complications secondary to FGM. Only 11.4%, of those who believed that FGM has health impact, have mentioned four and above complications. Thus, the study showed that the proportion of the respondents with adequate awareness about FGM is low (33.3%). Education status, age, marital status and source of information are closely associated with the level of awareness.

Respondents with primary or below primary education are three times likely to have low or no awareness ($p<.001$) as compared to secondary and post secondary level. There is strong association ($p<.001$) between awareness level and age of the respondents. The older age group (>45) is four times higher than the young to have low or no awareness about FGM. Moreover, married individuals are two times more likely to have low or no awareness. In this study, sources of information and awareness level of the respondents are found to have close association. Individuals who have single source are significantly affected ($p<001$) and are prone to have low or no awareness about it as compared to multiple sources.

The study carried out in Sudan, cited tradition as the main reason for FGM practice (45). Men still seem to prefer marriage to circumcised women (26). Similarly, in this study, custom and tradition (297) and requirement for marriage (148) were found the most two common reasons for practicing FGM in the community. This is high proportion and makes the struggle to eradicate for FGM longer and more difficult as tradition die-hard. In a society where there is no access to education and employment, inadequate financial strength of the family and social support from the government, securing the economic and social future of the daughter were found to be linked to marriageability.

Here is a statement forwarded by the respondent from focus group discussion for the question raised, do you continue circumcising your daughter? If so why?

> " Of course, said a person with a middle age raising his eye brows up and down, I shall have them circumcised exactly as their parents, grandparents and sisters were circumcised. I don't want my family to be austherasised by the community".
>
> "You know said the other person a little older than the former, I know a family who have three daughters, all of them are above eighteen, and are still not married because they are not circumcised and the people are pointing at them whenever they are out of their living place".

In the contrary, the religious leaders seem to have different opinion on the above question. The following explanation was given by the Muslim church leader and others also share the idea.

> "female circumcision has a very long history in our community and believed to be as one of good cultural practices. According to KURAN, said the leader clearing his throat, female circumcision is totally forbidden. Therefore, the practice has no religious background. However, due to the influence on our family and problems related with interaction to the rest of the community, at one time, we all are obliged to have our daughter circumcised. But now, personally, I have taken my own measure and decided not to circumcise my daughters. For instance, my youngest daughter is not circumcised and will not be circumcised in the future".

As also shown in other studies (25,34) men have taken a part in the decision to have their daughter circumcised. 33% of the respondents have expressed that they were involved in the decisions to have their daughter mutilated. This finding has very significant implications, as it would then be futile to neglect the men folk in the campaign against female circumcision. In general, the study has found out that the involvement of men, as in any reproductive health programs, in the prevention of female genital mutilation is low. The main reason for this could be fear of social criticism and insufficient health education. No record, in any health education topic including FGM, has been found at the health facilities. Although it is stated in the action plan of NCTPE no part of the government body, at the local level, has taken the initiative to implement the strategy for eradicating FGM.

It is thought that educated and influential people should set an example by abandoning genital mutilation in their own families. Better health education might also be effective because fear of criticism and ignorance of the after-effect, as cited by some of the respondents, maintains the practice of circumcision. This deserves more attention and social mobilization.

The result also showed the reasons for disapproving the continuation of FGM. This should be considered adequately because it may reflect the real feeling of the individual.

The suggestions of respondents who dis-approved the continuation of FGM, on the reasons for the continuation of the practice are great importance because it is these key people who might lead any campaign for its abolition.

The means to eliminate FGM is more than simple formal education. Behavioral change does not occur as a simple and direct response to receiving rationale or scientific information. For instance, many health personnel continue to smoke despite their knowledge of the harmful effects of the habit. Similarly, parents who fear about securing the economic and social of their daughter, if they do not undergo genital mutilation, will

need a strong motivation which can shift their positive attitude towards FGM and stop the practice than just scientific information. El Darer had found out that both sexes believed that circumcision give more sexual pleasure to the husband and this view was particularly strong among men (34). In this regard, the study has proved that the vast majority of the population (60.7%) is still in-favor of FGM. Significant number of the respondents believed that FGM gives more sexual pleasure and they prefer to have marriage with a woman who is circumcised. Education, source of information and marital status are statistically significant when we look at their attitude. Respondents with primary or below primary level of education are two times higher to have positive attitude as compared to those with secondary and above. Moreover, individuals with single source of information on FGM are more likely to support the continuation of the practice than multiple source ($P<.001$). Furthermore, married respondents were found to have positive attitude towards the practice as compared to single one. The reason for this could be lack of awareness about FGM and/or concern about the future life of their daughter that is marriageability.

More studies are needed to explore the effect of female genital mutilation on the sexual experience of women and men and how that in turn affects the stability of long-term unions.

5.1. Conclusions

WHO stated that any effort to change prevailing attitude towards this custom, the education of men is as critical as the wider efforts to improve the status of women including that of their reproductive health as a whole.

A higher proportion of the study population had no adequate awareness about FGM and its complications. It is clearly shown that the level of education has a direct relationship with the level of awareness.

As there was no health education program at the grass root level where this survey was conducted, which we believe is important and play a great roll to combat FGM, abolition of this ancient practice may take very long time unless efforts are initiated to implement such programs.

A very high proportion of the study population had still passive stand in the eradication of FGM. This is also greatly influenced by the level of education. The higher the educational level, the higher involvement in the eradication of the practice was found.

Significant number of the study population are still have positive attitude towards the continuation of FGM. As it is stated in the discussion, married respondents are supporting the continuation for the reason of securing their daughters future marital status. This shows that the issue of FGM is not only associated with social and political matters but also with economical status of the family and community at large.

5.3. **Recommendations**

- Education about the dangers of the practice seems insufficient and any education campaign must also be addressed to men. They must be persuaded not to require their future mate and daughters to undergo the procedure.

- Change cannot be expected overnight because FGM is intertwined with different social and cultural problems. As there is fear of stigmatization and isolation from the community on those who do not practice genital mutilation, the effort to bring a change in behavior must be targeted to individuals and as well as group of people. And understanding where an individual or community is in the process is important as it helps in re-designing and evaluating the education program.

- Establishing functional subcommittees at a local level is mandatory if close follow up and successful implementation of the eradication program is required.

- Further studies should be carried out to assess the knowledge and attitude of the local health personnel, as they are a core group of people activating the practice and some of them even perform this practice in their institution.

- More studies are needed to explore the effect of FGM on sexual experience of women and men and how that in turn affects the sustainability of long lasting union.

CHAPTER SIX

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Annex I

QUESTIONNARIES

Questionnaire number ___
Interviewer code ___
Date ___

Part I. Socio-demographic data

1. Adress
   1.1. Kebele _____
   1.2. House No_____
2. Age _____
3. Occupation____
1. Marital status
   1. Single____
   2.Married____
   3.Divorced___
   4.Widower___
5. Educational background
   1. No education
   2. Read and write
   3. Primary education
   4. Secondary education
   5. Post secondary

6. Religion
   1. Islam
   2. Protestant
   3. Catholic
   4. Orthodox
   5. Others
7. Ethnic background_____
8. Have you ever heard about FGM from before?
   ☐ Yes ☐ No

If yes, continue with the rest questions.

9. Sources of information about circumcision (✓)
   1.Health institution
   2.News paper
   3.Community leaders
   4.Radio and/TV
   5. Significant others
   6. School
   7. Other sources
   9. Not applicable

Part II

2.0 Level of awareness

2.1. Do you know circumcision? ☐ yes ☐ No

2.2. If yes.
What is circumcision?

2.3. Do you think circumcision has an impact on health?
☐ Yes ☐ No
(if no skip to Q 2.5)

2.4. If yes, which of the following do you think associated with the practice of female circumcision
List of complications: (✓)
1. Labor difficulties
2. Sexual discomfort
3. Bleeding
4. Infection
5. Menstrual problem
6. Difficulty in urination
7. Transmission of infectious diseases
8. Others
9. Not applicable

2.5. Do you know how common it is in your area
1. Very common
2. Common
3. Not common
4. Don't know

2.6.What do you think about the reasons for the practice of circumcision in your area ?

1. Custom & tradition	☐ yes ☐ No
2. Religious demand	☐ yes ☐ No
3. Purification	☐ yes ☐ No
4. Family honor	☐ yes ☐ No
5. Hygiene	☐ yes ☐ No
6. Protection of virginity	☐ yes ☐ No
7. Prevention of promiscuity	☐ yes ☐ No
8. Increasing sexual pleasure for the husband	☐ yes ☐ No
9. Reduce and control female sexuality	☐ yes ☐ No
10. Increase chance of marriage	☐ yes ☐ No
11. Improve fertility	☐ yes ☐ No
12. Others	

2.7 Female circumcision is violation of human right

☐ Yes ☐ No

Part III

3.0 level of involvement

3.1. Do you have daughters? ☐Yes ☐ No
(if no skip to Q 3.2)

3.1.1 If yes, are they mutilated? ☐ Yes ☐ No
9. Not applicable

3.1.2 If not, will they be mutilated? ☐ Yes ☐ No
If no, why ? 9. Not applicable

3.2. Do you have sisters?

☐ Yes ☐ No

3.1.1 If yes, are they mutilated? ☐Yes ☐ No
9. Not applicable

3.1.2 If no, will they be mutilated? ☐Yes ☐ No
If no, why ? 9. Not applicable

3.3.Were you involved in the decision making to have your daughter/sister mutilated

☐ Yes ☐No

3.4. If your daughter /sister came to you and said she did not want to be mutilated, what would you do?

1.I would force her
2.try to convince her
3.Support her idea
4.do not know

3.5. Have you ever attended health education/seminar/meeting on FGM?

☐ Yes ☐ No

3.6. Did you ever discuss about FGM with somebody?

☐ Yes ☐ No

If yes with whom_____

3.7. If your wife said your daughter should not be mutilated, what would be your response?

1.Agree with her
2.try to convince her
3. Decide to mutilate
4. Do not know

3.8. Who performs this procedure in this area?

1.Traditional birth attendants
2. Elderly mothers
3. Health personals
4. Others (specify)
5. Do not know

3.9. What does it costs? Do you think it is costy?

3.10. Do you approve that the practice of female circumcission should be sustainable?

☐ Yes ☐ No

If yes, why?(if no skip to 3.11)

3.11. For those who answered No

a. What reasons do you have for not supporting the continuation of female circumcision?

b. what do you think is the best way to stop this practice?

c. What do you think is the main reasons that this practice is allowed to continue?

3.12. Do you think male can play a role in the eradication of female circumcision?

☐ Yes ☐ No

If yes, how?

3.13. Have you ever been asked before about your feelings towards FGM practice ?

☐ Yes ☐ No

Part IV

4.0. Attitude

To what degree do you agree in the following statements?

4.1. FGM is not a serious problem in the community

1. S.dis 2.Disagree 3. Indifferent 4. Agree 5. S.agree

4.2. I believe FGM would continue and should not be stopped

1. S.dis 2. Disagree 3. Indifferent 4. Agree 5. S.agree

4.3.Females who are not mutilated are not faithful in their marriage

1. S.dis 2. Disagree 3. Indifferent 4. Agree 5. S.agree

4.4. I would prefer to marry mutilated women than none mutilated (unmarried)

1.S. dis 2. Disagree 3. Indifferent 4. Agree 5. S.agree

4.5. Men can make a difference in the practice of FGM in the community?

1. S.dis 2.Disagree 3. Indifferent 4. Agree 5. S.agree

4.6. FGM is a way of caring for beloved children

1. S.dis 2.Disagree 3. Indifferent 4. Agree 5. S.agree

4.7. For successful marital status a women must be mutilated

1. S. dis 2.Disagree 3. Indifferent 4. Agree 5. S. Agree

4.8. I believe that circumcision gives more sexual pleasure

1. S. dis 2.Disagree 3. Indifferent 4. Agree 5. S. Agree